

Last Name:
First Name:
Activity:
Date (s) of Activity:

Date

Parent/Guardian Signature

Contact Information:						
Name of Participant	Date of Birth	Grade		Phone #		
Address	City		State	Zip		
Parent/Guardian Name	Phone #		Alt. Phone #	Email	Email	
Parent Address (if different from Participant)	City		State	Zip		
Emergency Contact 1	Phone #	Alt. Phone	:#	Relationship		
Emergency Contact 2	Phone #	Alt. Phone	:#	Relationship		
Company Name	Policy #		Insure			
Current Doctor	Phone #		Immunization Current?			
Allergies/Reactions: (List below or write none)  Current Medications/Dosages: (List below or write none)			I give the leaders permission to administer the following over the counter drugs: (please check all that are allowed) Acetaminaphen Ibuprofen Naproxen Anti-nausea Anti-diarrhea			
Medical Conditions/Information to be aware of: (List below or write none)					Sudafed Benadryl	
Medical Conditions/Information to be aware of:  I, the undersigned parent or guardian of the mine any examination, x-ray, anesthetic, medical or su licensed under the provisions of the Medical Practices.	or child listed above, do hereby		=		Sudafe  Benadr	